PEIA Allergy Testing / Precertification Request

After completion, fax to (304) 353-8732 attention: PEIA Precert

Patient Name	
Date of Birth	
Insured (Employee Name)	
SS# for Insured	
Patient's Relationship to Insured	
Gender M/F	
Patient Phone Number	
Patient Address	
Proposed date of service	
Method of Allergy Testing for which precert is requested	
Number of tests to be included in panel	
Current diagnosis, symptoms and duration of symptoms	
Other conditions (co-morbidities)	
Previous treatment for this condition (including conservative treatment)	
Any prior allergy testing and outcome	
Expected outcome - is the patient willing to commit to allergy desensitization following skin testing?	
Physician information (name, address, phone number, fax number, and name of contact person)	
Facility information (if different)	
Information provided by:	
Date:	